

§ 148.210

(ii) The State law requires the coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) *Relation to section 2762(a) of the PHS Act.* The preemption provisions contained in section 2762(a) of the PHS Act and § 148.210(b) do not supersede a State law described in paragraph (e)(1) of this section.

(f) *Effective date.* Section 2751 of the PHS Act applies to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998. This section applies to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1999.

[63 FR 57562, Oct. 27, 1998]

Subpart D—Enforcement; Penalties; Preemption

§ 148.210 Preemption.

(a) *Scope.* (1) This section describes the effect of sections 2741 through 2763 and 2791 of the PHS Act on a State's authority to regulate health insurance issuers in the individual market. This section makes clear that States remain subject to section 514 of ERISA, which generally preempts State law that relates to ERISA-covered plans.

(2) Sections 2741 through 2763 and 2791 of the PHS Act cannot be construed to affect or modify the provisions of section 514 of ERISA.

(b) *Regulation of insurance issuers.* The individual market rules of this part do not prevent a State law from establishing, implementing, or continuing in

45 CFR Subtitle A (10–1–02 Edition)

effect standards or requirements unless the standards or requirements prevent the application of a requirement of this part.

§ 148.220 Excepted benefits.

The requirements of this part do not apply to individual health insurance coverage in relation to its provision of the benefits described in paragraphs (a) and (b) of this section (or any combination of the benefits).

(a) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances:

(1) Coverage only for accident (including accidental death and dismemberment).

(2) Disability income insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Coverage issued as a supplement to liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Credit-only insurance (for example, mortgage insurance).

(8) Coverage for on-site medical clinics.

(b) *Other excepted benefits.* The requirements of this part do not apply to individual health insurance coverage described in paragraphs (b)(1) through (b)(6) of this section if the benefits are provided under a separate policy, certificate, or contract of insurance. These benefits include the following:

(1) Limited scope dental or vision benefits. These benefits are dental or vision benefits that are limited in scope to a narrow range or type of benefits that are generally excluded from benefit packages that combine hospital, medical, and surgical benefits.

(2) Long-term care benefits. These benefits are benefits that are either—

(i) Subject to State long-term care insurance laws;

(ii) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Code; or

(iii) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(3) Coverage only for a specified disease or illness (for example, cancer policies), or hospital indemnity or other fixed indemnity insurance (for example, \$100/day) if the policies meet the requirements of §146.145(b)(4)(ii)(B) and (b)(4)(ii)(C) of this subchapter regarding noncoordination of benefits.

(4) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss, also known as Medigap or MedSupp insurance).

(5) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as CHAMPUS supplemental programs).

(6) Similar supplemental coverage provided to coverage under a group health plan.

[62 FR 16995, Apr. 8, 1997; 62 FR 31696, June 10, 1997]

PART 149 [RESERVED]

PART 150—CMS ENFORCEMENT IN GROUP AND INDIVIDUAL INSURANCE MARKETS

Subpart A—General Provisions

Sec.

- 150.101 Basis and scope.
- 150.103 Definitions.

Subpart B—CMS Enforcement Processes For Determining Whether States Are Failing to Substantially Enforce HIPAA Requirements

- 150.201 State enforcement.
- 150.203 Circumstances requiring CMS enforcement.
- 150.205 Sources of information triggering an investigation of State enforcement.
- 150.207 Procedure for determining that a State fails to substantially enforce HIPAA requirements.
- 150.209 Verification of exhaustion of remedies and contact with State officials.
- 150.211 Notice to the State.
- 150.213 Form and content of notice.
- 150.215 Extension for good cause.
- 150.217 Preliminary determination.
- 150.219 Final determination.

- 150.221 Transition to State enforcement.

Subpart C—CMS Enforcement With Respect to Issuers and Non-Federal Governmental Plans—Civil Money Penalties

- 150.301 General rule regarding the imposition of civil money penalties.
- 150.303 Basis for initiating an investigation of a potential violation.
- 150.305 Determination of entity liable for civil money penalty.
- 150.307 Notice to responsible entities.
- 150.309 Request for extension.
- 150.311 Responses to allegations of non-compliance.
- 150.313 Market conduct examinations.
- 150.315 Amount of penalty—General.
- 150.317 Factors CMS uses to determine the amount of penalty.
- 150.319 Determining the amount of the penalty—mitigating circumstances.
- 150.321 Determining the amount of penalty—aggravating circumstances.
- 150.323 Determining the amount of penalty—other matters as justice may require.
- 150.325 Settlement authority.
- 150.341 Limitations on penalties.
- 150.343 Notice of proposed penalty.
- 150.345 Appeal of proposed penalty.
- 150.347 Failure to request a hearing.

APPENDIX A TO SUBPART C OF PART 150—EXAMPLES OF VIOLATIONS

Subpart D—Administrative Hearings

- 150.401 Definitions.
- 150.403 Scope of ALJ's authority.
- 150.405 Filing of request for hearing.
- 150.407 Form and content of request for hearing.
- 150.409 Amendment of notice of assessment or request for hearing.
- 150.411 Dismissal of request for hearing.
- 150.413 Settlement.
- 150.415 Intervention.
- 150.417 Issues to be heard and decided by ALJ.
- 150.419 Forms of hearing.
- 150.421 Appearance of counsel.
- 150.423 Communications with the ALJ.
- 150.425 Motions.
- 150.427 Form and service of submissions.
- 150.429 Computation of time and extensions of time.
- 150.431 Acknowledgment of request for hearing.
- 150.435 Discovery.
- 150.437 Submission of briefs and proposed hearing exhibits.
- 150.439 Effect of submission of proposed hearing exhibits.
- 150.441 Prehearing conferences.
- 150.443 Standard of proof.
- 150.445 Evidence.
- 150.447 The record.